The PATHWAYS Program
c/o MSPP, 1208 VFW Parkway, West Roxbury, MA 02132
West Roxbury Education Complex

INFORMED CONSENT FOR THE PROVISION OF PSYCHOTHERAPEUTIC SERVICES AND DIAGNOSTIC EVALUATIONS (Adult Clients)

I, _____,
(Printed Name of Client)

consent to participate in psychotherapeutic services (individual and group counseling sessions) and/or diagnostic evaluations through the PATHWAYS Program at the West Roxbury Education Complex. I understand that these services will be provided free of charge by qualified mental health interns or clinicians. I further understand that services are being offered as part of a collaboration among the West Roxbury Education Complex, the Massachusetts School of Professional Psychology, the Massachusetts Society for the Prevention of Cruelty to Children, and the Haitian Mental Health Network. I also understand that, in order to better serve the needs of clients who are enrolled in the PATHWAYS Program, interns and clinicians will consult with school administrators, teachers, and other personnel.

PLEASE CHECK ALL THAT APPLY:
- □ Intake Assessment/Evaluation
- □ Individual Counseling
- □ Group Counseling

_____ _____
Signature of Client Date

STATEMENT OF CONFIDENTIALITY

Statements made during the course of diagnostic evaluations or therapy sessions by clients or family members are treated as confidential information. Parents and legal guardians of a minor child below the age of eighteen, who is the identified client, will have access to the treatment record of their child. General and non-sensitive information that is relevant to the overall care of the client may be shared with teachers, medical and mental health providers and other specialists. (Please review the *Authorization for Release of Protected Health Information* form.)

There are exceptions, mandated by state and federal law, which make it necessary for providers and child care professionals to breach confidentiality. The staff may be required by state and federal laws to release confidential information about a client to an appropriate individual or authority when a particular kind of situation occurs. These exceptions to confidentiality are:

1. Information relating to the abuse or neglect of a child by parents, guardians, or other care providers;
2. Information about clients who present a clear and present danger to themselves or others; and/or
3. Information relating to professional consultations that are intended to enhance services provided to clients and their families. Confidential information will not be released unless it is essential to the consultation.

I, _____, have read, understand and have received
(Print Name)

a copy of the statement of confidentiality.

_____ _____
Signature of Client Date

_____ _____ _____
Witness Title/Position Date